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ABSTRACT

This paper is a guide to the location, decor and record keeping of a college counseling service. It delineates the issues and concerns that will dictate the choice of each of these aspects of the counseling service. The choice of location can be determined only after considering the issues of privacy, accessibility and confidentiality. Thus, for example, the placement of guidance services in the administration building is ruled out. The student health service building is the most suitable locale if a separate facility cannot be provided, and this paper discusses the advantages and disadvantages of such a placement. The physical decor of the counselor's office is considered very important in creating a warm, supportive emotional space. Ways of achieving this effect are discussed. Careful record-keeping is potentially helpful in supporting the overall philosophy and practice of the counseling center, and the paper discusses means by which this potential can be realized. (NG)

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THE COLLEGE COUNSELING OFFICE

The Theory and Practice of Location, Decor, and Records

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Locating the counseling office is an important decision because it reflects the college's philosophic attitude toward mental health services and also its practical commitment through the use students can make of it. The attitudes this placement demonstrates include accessibility, how accessible the college wishes to make counseling services to the student, privacy, how much physical privacy the location of the counseling office can afford the student, and confidentiality, the privacy of communication and record-keeping between the counselor and his clients. These criteria, access, privacy, and confidentiality, can help administrators and counselors rule out some locations because they cannot be met completely, or because they cannot establish meaningful priorities among these criteria.

First and most obvious is the administration building. Under no circumstances should counseling services be placed in the same building with deans, registrars, and other real and symbolic administrative authority figures, and by authority we mean student personnel workers who are responsible for discipline and evaluation. Student paranoia is usually high by virtue of their adolescence and recent politics, without having to add to it by confusing or challenging their sense of trust in placing counseling and administrative services together. This is not to say that many student personnel workers and administrators other than counselors are not warm, accepting, and confidential

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persons-only that students make more use of a counseling service when these two areas are not housed together. Students are not very likely to either use a service, or, once using it, talk freely to counselors who work in buildings where much of campus discipline and academic record keeping takes place. Depending upon the size of the campus, there is going to be a good deal of professional and social interchange between deans and other student personnel workers in reference to students. Keeping these services in separate locations can reduce the possibility of both intentional and non-intentional exchange of information. The primary factor in creating student trust in counselor confidentiality will still be in the behavior of the counselor and the quality of the counseling relationship. Sensitive location of the counseling office can help support this interpersonal trust.

The student union, although not as undersirable as the administration building, is not the most appropriate location for counseling services. It is true that much activity does occur in many student unions, eating, socializing, and organizational meeting, but the excessive activity could undercut the privacy and confidentiality of a counseling relationship. Students still do not want to be identified by the fact that they have problems they seek help for; a counseling center in the student union could over-publicize its clientele.

The student union, however, can be very useful in counseling related areas. Peer counseling programs such as drug assist, suicide prevention, and sex information services can be located in the student union where they will have a good visibility and accessibility for students. These outreach counseling programs can then make referrals to other counseling offices located in other buildings.

Counseling services probably should not be located in academic buildings either, particularly academic buildings that also house faculty offices. Students like to keep their relationships with college staffs distinct and individually negotiable and do not want faculty members necessarily know they are seeking help for personal problems. Even though some students ask for more intimate relationships with faculty, this usually does not mean a clinical or counseling relationship; they may want friendship and personal response to themselves and their work but not therapy. Unfortunately separating counseling offices from academic, administrative and student activities buildings minimizes the number of personal and professional contacts the counselor has with his colleagues. However, the good of keeping these different aspects of college service separate, the good in terms of usefulness for students, outweighs the personal disadvantages for the counselor. The counselor will have to compensate for these physical distances by actively seeking out other members of the college community.

The student health service (infirmary) or a separate house are the most appropriate locations for counselors, although each has its own particular drawbacks. Any decision for location will obviously have to consider what facilities are available and which of the priorities suggested above each college deems important. The advantages and disadvantages of using the college infirmary are interrelated. On the one hand many students still do see their personal problems as problems that are either associated with or identical to their medical problems and that care of these problems involves some sort of traditional therapeutic relationship, meaning the doctor-patient relationship. Not only do they expect a specific kind of professional, clinical relationship,

but indeed the physical decor that goes with it - receptionist, waiting room, and private offices. When the student hasn't felt good in the past, he has had a clearly defined relationship in which to take care of that bad feeling, by putting himself in the role of patient and having a doctor take care of him. There may be theoretical disadvantages (see R. D. Lang and Thomas Szasz) of confusing physical and emotional problems and subsequently using the medical model as a means of practicing those theories, but the reality of the matter is that students and people in general continue to need, as demonstrated by their use, the doctor-patient relationship, as the form in which they begin recovering their physical and emotional selves. If there is going to be any major dispelling of this old model, it will have to take place in the counseling relationship itself and through the support of personnel that complement the counseling relationship. The quality of the counseling relationship, the degree to which the relationship manifests trust, empathy, respect and communication, will be the dynamics by which some of the arbitrary, depersonalized symbols of the medical model will take on less importance. The counselor may also more directly discuss the differences between a counseling relationship and other clinical relationships. This kind of attitude change and practice only takes place through experience, and, in effect, each counseling session becomes a reinforcement of that new attitude. If students do still view their problems as medically related and need to be treated in that context what then are some of the practical ways in which the emphasis can be taken off the medical metaphor?

If the counseling offices are located in the infirmary, it is useful if both its entrance and receiving rooms are, if possible, private. If we are

to de-emphasize the medical model, students should have less contact with medical personnel. Nurses should not serve as secretaries to counselors nor should infirmary waiting rooms be used as areas for students waiting to see counselors. Again doctors and nurses can be good supportive people and often they are helpful at some point in the total counseling relationship, however, the more distinction there can be made between emotional and physical problems, the more emphasis there will be upon the student's own role in taking responsibility for dealing with his problems. The more we distinguish between the two services for emotional problems, the less the student comes to view himself as sick and as seeing his source of help and recovery as outside of himself in the hands of medical professionals. Keeping the services separate may help to place less emphasis on symptomatic treatment and more emphasis on encountering the whole person; it will also reduce the possibility of joint record keeping and over stereotyping of the student as a "sick" person.

On the other hand, as always, there are some practical advantages to having medical and counseling services in the same building. In addition to the Dean's office, the student health service sees the largest number of students who need help. For that reason the student health service is usually geographically very accessible and it is a building which most students know about. In addition to accessibility and visibility, locating counseling offices in the infirmary allows good immediate referrals to be made back and forth between physicians, psychiatrists and counselors. And the referral system can be mutual. Often a student will come to see the college physician and say he doesn't feel well; during the course of that examination the doctor and student will identify the problem as an emotional problem at which point it can be very helpful for

the doctor to be able to offer counseling support which is immediately accessible. After the student has identified to himself and some helping professional that he has a problem, the closer an appointment can be made for the student to the identification of that problem, the greater chance there is that he will talk to somebody about it.

The counselor, too, may wish to refer his client to the medical staff for consultation regarding possible organic influence to a particular problem, or to a psychiatrist who may be attached to the health services for further therapeutic support which may take the form of medication. As we said in an earlier chapter, stereotypically there exists a hierarchical attitude about mental health services. Being treated by a psychiatrist or general practitioner can imply the problem is intense and pathological; indeed this may be true, but in fact psychiatrists, psychologists and counselors can be qualified to work with a range of emotional problems. It is important in the development of any counseling service to undercut and discourage this hierarchical attitude about emotional problems and their treatment. This is a problem that cannot be handled theoretically but must be met through good communication among staff members, and the trust which understanding of their own attitudes about "hierarchical" treatment, each individual student comes to feel based on his own experience with mental health workers. The degree to which communication, respect, and mutual referrals take place among the different student health workers (physicians, psychiatrists and counselors) will help to influence the anxiety of the student toward receiving help from different kinds of mental health workers. For example, no one mental health worker on the campus should be responsible for what may be called the more "extreme" forms of

emotional problems. It probably will be true that the psychiatrist eventually will become involved with these kinds of problems, but for the counselor and others to refer all of their more serious problems to the psychiatrist reinforces old attitudes and hierarchies about this kind of treatment. This attitude unfortunately can remove the counselor from the treatment field, because he may not be perceived as being able and trained to help different kinds of problems. Again good communication and progressive philosophy among helping professionals will allow students to receive a variety of support.

A third reason for including counseling offices in an infirmary building is logistical. Most student health services operate twenty-four hours a day which means that there is constant telephone coverage. Most counseling offices cannot afford to have a counselor there twenty-four hours a day or do not have hot line services attached to the counseling offices. The twenty-four hour call-in availability of the infirmary becomes a way in which counselors can be reached after office hours. Using the infirmary telephone is a better alternative than campus security, probably the other continuous service, because of the usual student attitude toward police and also the degree to which involving security intensifies or alters the problem. The relationship between counselors and security officers is very important and is discussed elsewhere.

The best location for counseling services would be a small house centrally located on campus and within walking distance of the infirmary. Many schools do have the luxury of owning small private houses on or near their campus. Having their own facility allows counselors the advantage of not being directly associated with other interest groups - the biases tied to

these groups - and subsequently gives the student the privacy, confidentiality, and "objectivity" he needs. A small house can be a place which through its decoration and presentation is warm, homey, and open.

This facility can have a receiving room staffed by a woman or man who has three primary functions. First, they receive the student; they receive him by taking care of the business he may want to do, setting up an appointment with a counselor, picking up a recommendation, or checking an appointment date. Second, besides doing pre-counseling work the receptionist can set and communicate the tone of the counseling center to its clientele. The receptionist's own warmth and attitudes about needy students is very important in helping the student feel comfortable and accepted in seeking help and in establishing an emotional context of warmth and goodwill which the counselor will hopefully continue. Third, the receptionist is there to listen to some aspect of the student's problem, and this listening is both active and passive. Receptionists should not necessarily be trained counselors nor should they be expected to do what counselors do both in activity and responsibility, but indeed their natural sensitivities, if the person is carefully selected, will create an atmosphere in which the student seeking help will feel somewhat comfortable in relaying parts of their problem before seeing the counselor. This is not to suggest that the receptionist should ask the student what he wishes to speak to the counselor about, but rather if that option is there, created by the warmth of the receptionist, the student may feel that he can share as much as he wishes with that receptionist. In many instances this reduces some of the preliminary anticipatory anxiety prior to the counseling session. If the counseling relationship is continuous, a relationship between the receptionist and the student

will develop over the same period of time. Indeed what the student says to the receptionist before and after counseling sessions can be indicative of how the student views counseling. It is very useful to include and take seriously receptionist's observations and intuitions about students he or she meets. They can be helpful in giving the counselor a larger impression of how that student relates to people outside of his office.

A small house would also include private offices for each counselor and some larger space for training and group counseling sessions. An additional room can be used for relaxing and sleeping purposes. Occasionally a student who does not need hospitalization or who does not need to stay overnight in the student health service may need a temporary place to which he can pull back. A room where he may sleep, study or relax for an afternoon or part of an evening may be provided as part of the counseling service to serve this particular purpose.

The physical decor of the counselor's office is very important in establishing pre-counseling attitudes and in creating a supportive emotional space in which counseling can occur. Just as the counseling center itself should be accessible and confidential so, too, should the counselor's private office reflect these two qualities. It should be accessible by being comfortable, attractive, and warm and private so that conversations within the office cannot be heard from outside it, and that conversations or work outside of the counselor's office cannot intrude on the counseling session. Carpeting, indirect lighting and careful choice of decorations can be helpful in setting a tone for counseling sessions. If the counselor feels comfortable in his office this feeling will be evident in the design of the office and help set a context in which

counseling begins. Some of the counselor's photographs, books and other personal objects should be part of the office as a way of helping the client make contact with the person of the counselor. Also if the counselor's office is homey, certain aspects of transferance may be stimulated. A counselor's office tells the client something about his counselor and can create an open and accepting tone by its decoration and by the options it offers within its own geography. For example, it is useful to have a number of different chairs in the office at different distances away from the counselor so that the client can make his own initial decision as to how close he wishes to sit. Without over-interpreting this decision, at some point in the relationship the counselor may choose to describe this non-verbal decision as a lead in to exploring emotional and physical distance in relationships. Each aspect of the counselor's presentation, his personality, clinical skill, and setting, can be used in developing this special helping relationship.

The third component of the counselor's office, record-keeping, is as important as the location of the counselor's office and its decoration. The practice of record-keeping functionally reflects the previous criteria of availability and confidentiality. Record-keeping - what gets put down in records, how long records are kept, and for what purposes they are made - is an issue raised within our general society and with specific intensity among college students. Record-keeping by counselors, physicians, or deans can be viewed by students as a process directly related to academic assessment. The fact that other college staff members make observations about them and perhaps record these observations ties in for students to the question of the validity

and necessity of any evaluation, whether it be clinical or academic evaluation. If there is to be developing trust in the counseling relationship, the issue and details of record-keeping, if indeed the counselor does keep records, should not only be made clear to the client, but, perhaps in some cases, negotiated with him. If in the initial interview the counselor discusses with his client how counseling works and what his expectations may be, this sometimes can be a good time to discuss the issue of record-keeping. If this isn't part of the counselor's approach, this topic can be discussed when the client feels a need to raise it.

Four practices in record-keeping can be helpful in supporting the overall philosophy and practice of the counseling center. First, although some clinicians are trained to take notes during the counseling interview, or need to take notes as a result of seeing numerous clients or poor memory, this practice places a greater emphasis on record-keeping than is necessary, distracts the clients and removes the counselor from total involvement in the counseling relationship; it is difficult to write while trying to listen and respond at the same time. Second, if these records and notes are kept in a public place, that is the counseling office itself as part of the institution, only objective facts should be recorded. These facts, details expressed by the client and observational data about the interview, can be kept to keep the counselor informed from session to session and to serve as <u>representational</u> data of more subjective observations and interchanges which the counselor for private and legal reasons may not wish to include on a record possibly open to public scrutiny. The area of legal confidentiality and privileged communication is still ambiguous in some states and if not ambiguous, it is still capable of

being influenced in ways that could be potentially harmful to both the counselor and his clients. For this reason records kept in the counselor's office should be objective in nature and not include facts potentially harmful to the client. These facts may include areas of sexual or criminal behavior or details about people related to the client. Subjective impressions and theoretical implications of individual cases can be kept as part of a counselor's own personal work; keeping these at home can be a way of keeping them out of the potential public domain. Finally it may be useful for the counselor to share his objective clinical notes with his client at different points in their relationship. If record-keeping becomes an issue of trust and confidence between the counselor and the client, the counselor should not hesitate in sharing his notes with the client. This can help establish trust through verification. In addition, sharing these notes periodically or near termination can be a way of helping the client review both what has happened to the client and how the counseling relationship has developed over a period of time. Sharing these notes is one way of sharing growth and observations about behavioral change. These records should be available to clients during the relationship and to other helping professions who with the signed permission of the client may need these records. Three to five years is a useful time for maintaining records after the counseling relationship is terminated, for purposes of review if the client wishes to re-establish the relationship or if the client wishes to have these notes forwarded to another counselor.

Each of these areas, location of the counseling center, physical qualities of the counselor's office, and methods of record-keeping are significant in helping to establish and maintain a good counseling relationship. They are

necessary but not sufficient conditions which help validate both the philosophical position of the counselor and his interpersonal exchanges.